

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10743 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Fla.</u> b. COUNTY <u>Hillsborough</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural</u>		c. LENGTH OF STAY IN 1b <u>488-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>3009 Curtis St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ansel</u> Middle <u>Leonel</u> Last <u>Acosta</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 20 1922</u>
9. AGE (In years last birthday) <u>34 1/2</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Fla.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Joseph Acosta</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Altamuse, Dredie</u>		Address <u>3009 Curtis St. Tampa, Fla.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 822x DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>SKULL FRACTURE</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>0</u> <u>0</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURE RIGHT TIBIA & FIBULA</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>WAS THROWN ONTO HIGHWAY WHEN AUTO MOBILE OVERTURNED</u>	
20c. TIME OF INJURY Month, Day, Year <u>SEPT 26 1958</u> Hour <u>5:45</u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u> </u> of work <u> </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <u>US 113 Rd. SUBWAY</u>		20f. (City or town) <u>WORCESTER</u> (County) <u>Ind.</u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Robert C. LaMar</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Robert C. LaMar</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/27/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/27/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or county) <u>Tampa</u> (State) <u>Fla</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hemin</u>		ADDRESS <u>Snow Hill, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	

MEDICAL CERTIFICATION

23

2

OF STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

RESIDENCE

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10739

10750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>S.</u> Last <u>Dugden</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27-1877</u>
9. AGE (in years last birthday) <u>80 1/2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert J. Dugden</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Miss Mary E. Dugden, Newark, md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>260x acute myocardial infarction</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>9-2-58</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-31-58</u> to <u>9-2-58</u> , that I last saw the deceased alive on <u>8-31-58</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford E. Schott</u>		DATE SIGNED <u>Berlin, md.</u>	
PHYSICIAN'S NAME (Type) <u>Clifford E. Schott</u>		<u>Berlin MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 4-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay E. Harris</u>		ADDRESS <u>Snow Hill, md</u>	
23b. REC'D BY REGISTRAR <u>SEP 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

CERTIFICATE OF DEATH

10750

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1925</i>	
5. PLACE OF BIRTH <i>Baltimore, Md</i>		6. OCCUPATION <i>Teacher</i>		7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>	
9. DATE OF DEATH <i>Dec 10 1970</i>		10. TIME OF DEATH <i>10:30 AM</i>		11. PLACE OF DEATH <i>Home</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF PHYSICIAN <i>John Doe</i>		15. SIGNATURE OF CORONER <i>John Doe</i>		16. SIGNATURE OF JURY <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF PHYSICIAN <i>John Doe</i>		20. SIGNATURE OF CORONER <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF PHYSICIAN <i>John Doe</i>		24. SIGNATURE OF CORONER <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF PHYSICIAN <i>John Doe</i>		28. SIGNATURE OF CORONER <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>		31. SIGNATURE OF PHYSICIAN <i>John Doe</i>		32. SIGNATURE OF CORONER <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF PHYSICIAN <i>John Doe</i>		36. SIGNATURE OF CORONER <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF PHYSICIAN <i>John Doe</i>		40. SIGNATURE OF CORONER <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF PHYSICIAN <i>John Doe</i>		44. SIGNATURE OF CORONER <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF PHYSICIAN <i>John Doe</i>		48. SIGNATURE OF CORONER <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF PHYSICIAN <i>John Doe</i>		52. SIGNATURE OF CORONER <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF PHYSICIAN <i>John Doe</i>		56. SIGNATURE OF CORONER <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF PHYSICIAN <i>John Doe</i>		60. SIGNATURE OF CORONER <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF PHYSICIAN <i>John Doe</i>		64. SIGNATURE OF CORONER <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>		67. SIGNATURE OF PHYSICIAN <i>John Doe</i>		68. SIGNATURE OF CORONER <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF PHYSICIAN <i>John Doe</i>		72. SIGNATURE OF CORONER <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF PHYSICIAN <i>John Doe</i>		76. SIGNATURE OF CORONER <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>		79. SIGNATURE OF PHYSICIAN <i>John Doe</i>		80. SIGNATURE OF CORONER <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF PHYSICIAN <i>John Doe</i>		84. SIGNATURE OF CORONER <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF PHYSICIAN <i>John Doe</i>		88. SIGNATURE OF CORONER <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>		91. SIGNATURE OF PHYSICIAN <i>John Doe</i>		92. SIGNATURE OF CORONER <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF PHYSICIAN <i>John Doe</i>		96. SIGNATURE OF CORONER <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF PHYSICIAN <i>John Doe</i>		100. SIGNATURE OF CORONER <i>John Doe</i>	

10751

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BERLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES F. HAGGERTY		4. DATE OF DEATH Month Day Year SEPT 26 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 17, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ANTIQUE DEALER		10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS	
11. BIRTHPLACE (State or foreign country) PHILADELPHIA PA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS HAGGERTY		14. MOTHER'S MAIDEN NAME SARAH MORRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Address Mrs. SIDNEY DAVIS, BERLIN MD (RFD)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocarditis 431X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 149 perleusion DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-1- 19 56 to 9-26-58 that I last saw the deceased alive on 9-23 19 58 , and that death occurred at 5:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifford E. Schott M.D.		ADDRESS (Street, city or town, State) Berlin Md DATE SIGNED	
PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTT		BERLIN MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-30-58	22c. NAME OF CEMETERY OR CREMATORY HOLY SEPULCHRE	22d. LOCATION (City, town, or county) (State) PHILADELPHIA PA.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Anna R. Burbage Berlin Md.		24a. REC'D BY REGISTRAR DATE SEP 30 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10752

CERTIFICATE OF DEATH

10741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Newark				c. LENGTH OF STAY IN 1b 12 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.O. Box 17				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle T. Last Kennedy				4. DATE OF DEATH Month 9 Day 14 Year 19 58			
5. SEX Male	6. COLOR OR RACE AA C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1894	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 11 Days 26 Hours Min. 	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Utility		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) York, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Kennedy				14. MOTHER'S MAIDEN NAME Nina Kennedy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO. 17-19		17. INFORMANT Mrs. Minnie R. Kennedy, Newark, Md., Box 17			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO right hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential hypertension (c) 						INTERVAL BETWEEN ONSET AND DEATH 7 days about 4 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month Day Year 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 4-7 , 19 57 , to 9-12 , 19 58 , that I lost saw the deceased alive on 9-12 , 19 58 , and that death occurred at 12:20 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George U. Sully, Jr. M.D.				ADDRESS (Street, city or town, state) Berlin, Md.		DATE SIGNED 9/16/58	
PHYSICIAN'S NAME (Type) Dr. I. U. Sully, Jr. M.D. Berlin, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-18-58	22c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		22d. LOCATION (City, town, or county) Newark, Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				24a. REC'D BY REGISTRAR DATE SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MASSACHUSETTS DEPARTMENT OF HEALTH—FALLINGOP, 13

10746

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lloyd Middle Lane Last		4. DATE OF DEATH Month September Day 11 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1870
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher		10b. KIND OF BUSINESS OR INDUSTRY Vault	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Lane	
14. MOTHER'S MAIDEN NAME Maria Robins		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Emma Green, Pocomoke City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ca of Prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/10/58 , 19____, to _____, 19____, that I last saw the deceased alive on 9/10 , 19 58 , and that death occurred at 7 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Edgar A. D. J. J. J. M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/58	
22c. NAME OF CEMETERY OR CREMATORY Halls Hill Cem.		22d. LOCATION (City, town, or county) (State) Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Whorton - new Church, Va.		24a. REC'D BY REGISTRAR DATE SEP 16 58	
24b. REGISTRAR'S SIGNATURE Carroll S. Thoms			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

ARMY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, TO

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10747

CERTIFICATE OF DEATH

10743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City		c. LENGTH OF STAY IN b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Adial --- Pusey		4. DATE OF DEATH Month Day Year September 1 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Littleton T. Pusey		14. MOTHER'S MAIDEN NAME Harriett Jane Hudson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No ---		16. SOCIAL SECURITY NO. 214-28-7972	
17. INFORMANT Mrs Sarah E. Pusey, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Insufficiency DUE TO (b) Cardiac & Generalized Arteriosclerosis, severe DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Psychosis secondary to (b) alone INTERVAL BETWEEN ONSET AND DEATH many years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Sept. 19 58, to 1 Sept. 19 58, that I last saw the deceased alive on 1 Sept. 19 58, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE N. E. Sartorius, Jr. M.D. Pocomoke, Md. DATE SIGNED 9-2-58 PHYSICIAN'S NAME (Type) N. E. Sartorius Jr. Pocomoke City, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-7-58	
22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Worcester County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson		ADDRESS Pocomoke City, Md.	
24a. REC'D BY REGISTRAR DATE SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10748

CERTIFICATE OF DEATH

Reg. Dist. No.

10744

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 415 Laurel Street				d. STREET ADDRESS 415 Laurel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Savage				4. DATE OF DEATH September 2 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 28, 1906	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Edward Savage Sr.				14. MOTHER'S MAIDEN NAME Mary Lou Sample			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-09-3777		17. INFORMANT Edward Sturgis Address 508 5th Ave. Pocomoke city, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Atherosclerosis DUE TO Essential Hypertension CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. Broncho pneumonia 1 wk PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/26/1958 to 9/1/1958 , that I last saw the deceased alive on 9/1/58 , 19 58 , and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Cecil A. Duverney M.D.							
PHYSICIAN'S NAME (Type) CECIL A. DUVERNEY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/6/58		22c. NAME OF CEMETERY OR CREMATORY Eastville Cem.	
22d. LOCATION (City, town, or county) (State) Eastville, Va.							
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Va. ADDRESS				24a. REC'D BY REGISTRAR DATE SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BOSTON, 18

200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gordonsville, Syria</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elton</i> First <i>Lee</i> Middle <i>Snead</i> Last		4. DATE OF DEATH Month <i>Sept</i> Day <i>22</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1915</i> <i>Nov-25-1915</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck driver - Pontiac</i>		11. BIRTHPLACE (State or foreign country) <i>Orlando Fla</i>	
13. FATHER'S NAME <i>Oliver Snead</i>		14. MOTHER'S MAIDEN NAME <i>Clara Beckett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-14-8444</i>	
17. INFORMANT <i>Wife</i> Address <i>Reynolds Road Gordonsville Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>His occupation</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>N. E. Sartorius</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>N. E. Sartorius</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept 25/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cool Springs Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Gordonsville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas P. Morris, Snow Hill Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 24 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneaf</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF CALIFORNIA - DEPARTMENT OF HEALTH - BATHING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10754

CERTIFICATE OF DEATH

10746

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Marcus</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Marcus</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>S.</u> Last <u>Stevens</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19-1890</u>
9. AGE (In years last birthday) <u>67 1/2</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Reconobelt, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Brittingham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-0789</u>	
17. INFORMANT <u>Mrs Helen B. Stevens, Snow Hill, md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CANCER OF LUNGS</u> <u>199.2</u> DUE TO <u>(ORIGINAL SOURCE UNDETERMINED)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 YR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>58</u> , to <u>Sept 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 27</u> , 19 <u>58</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C La Mar</u>		M.D. <u>104 Bay St</u>	
PHYSICIAN'S NAME (Type) <u>Robert C La Mar M.D.</u>		ADDRESS (Street, city or town, state) <u>Snow Hill, Md.</u>	
DATE SIGNED <u>9/29/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 30 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bates Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton D. Dennis</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR <u>SEP 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kears</u>	

10755

CERTIFICATE OF DEATH

Reg. Dist. No.

10747

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook, Del. Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Seabrook, Del. - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Esther</u> First <u>Milbourne</u> Middle <u>Junnell</u> Last		4. DATE OF DEATH <u>Sept. 16</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1915</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Milbourne</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Waters Milbourne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Walter Junnell</u>		Address <u>Seabrook, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Acute pulmonary edema</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular disease</u> (c) <u>4 yrs 8 mos</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 mos 7 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12-30, 1958</u> to <u>9/16, 1958</u> , that I last saw the deceased alive on <u>9-16, 1958</u> , and that death occurred at <u>5:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry G. Shelly, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin, Md.</u> DATE SIGNED <u>9/18/58</u>	
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr. M.D.</u>		<u>Berlin, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Sept. 20</u>	<u>Mt. Wesley</u>	<u>Snow Hill Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Watson</u>		ADDRESS <u>Pocomoke City, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 23 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10756

CERTIFICATE OF DEATH

10748

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 GRACE ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES EDWARD WEST</u>		4. DATE OF DEATH Month Day Year <u>SEPT 5 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 13, 1909</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTOR SELF EMP.</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM WEST</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE ARVEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-05-0761</u>	
17. INFORMANT <u>MRS. J. E. WEST</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Renal Disease, etc</u> DUE TO <u>2-2 yrs</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal Encephalosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1956</u> to <u>Sept 5, 1958</u> that I last saw the deceased alive on <u>Sept 5, 1958</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Herman H. Robbins</u> M.D.		<u>Berlin, Md</u>	
PHYSICIAN'S NAME (Type) <u>HERMAN H. ROBBINS M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Surbey</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>SEP 9 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

